

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WISCONSIN

A. The following charges are imposed on the medically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
				The charge for each service was computed by reviewing the average amount billed for the service in a recent period and comparing that average charge to the maximum allowable under 42 CFR 447.54. If there is any variation on average charges for specific procedures within a service category, the lowest maximum allowable was chosen (e.g., \$.50 for OTC drugs) for the entire category.
AMBIOPOLYMER SERVICE			X	\$3.00 per surgery.
AUDIOLOGICAL TESTING			X	\$1.00 per procedure.

OFFICIAL

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
CHIROPRACTIC SERVICES				
Office Visits/Manipulations			X	\$1.00 per procedure.
Laboratory			X	\$1.00 per procedure.
Radiology			X	\$3.00 per procedure.
COMMUNITY CARE ORGANIZATION (CCO)			X	\$3.00 per month.
DAY TREATMENT SERVICES			X	\$.50 per day. (Outpatient psychotherapy services in excess of 15 hours or \$500.00 of accumulated services per recipient per year rate exempt from copayment.)
DENTAL SERVICES INCLUDING ORTHODONTIA			X	\$0.50 - \$3.00 per service depending on the price of the service.

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TN #97-021
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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
DRUGS AND DISPOSABLE MEDICAL SUPPLIES Legend Drugs, OTC's, Disposable Medical Supplies (Except Family Planning Items)			X	\$1.00 per each new and refill legend drug prescription up to \$5.00 per pharmacy per month. \$0.50 per item for each new and refill OTC drug prescription and disposable medical supply. (No monthly limit for OTCs or disposable medical supplies .)
DURABLE MEDICAL EQUIPMENT Durable Medical Equipment Purchase			X	Between \$0.50 and \$3.00 depending on the price of the item.
EPSDT (HealthCheck)			X	\$1.00 per screening for recipients age 18 and over.
GLASSES Dispensing Complete Appliance Frame, Temple, or Lens Replacement Repair Service			X X X	\$3.00 per procedure. \$2.00 per procedure. \$0.50 procedure.

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
HEARING AIDS AND SUPPLIES				
Hearing Aid Purchase			X	\$3.00 per service
Hearing Aid Accessories/Repair			X	\$1.00 maximum per service.
HOSPITAL SERVICES				
Inpatient - Effective 11/1/83			X	\$3.00 per day up to \$75.00 per stay.
Outpatient - Effective 1/1/88			X	\$3.00 per visit.
INPATIENT STAYS IN INSTITUTIONS FOR MENTAL DISEASES (HOSPITALS)			X	\$3.00 per day up to \$75.00 per stay.

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
MENTAL HEALTH SERVICES				
Individual and Group Mental Health/AODA Therapy			X	Between \$0.50 and \$3.00 depending on the cost of the service. (No copayment required after 15 hours or \$500 of services have been provided per recipient per calendar year.)
Evaluations				
Biofeedback				
Family Therapy and Collateral Interviews			X	\$2.00/hour per family per 60 minutes. (Outpatient psychotherapy/AODA and biofeedback services in excess of 15 hours or \$500.00 of accumulated services per recipient, per calendar year, are exempt from copayment.)
NURSE PRACTITIONER SERVICES (See Physician Services)				

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
OCCUPATIONAL THERAPY				
Individual or Group Therapy/Evaluation			X	Between \$0.50 and \$3.00 depending on the cost of the service. (No co-payment required after 30 hours or \$1,500 of services have been provided per recipient per calendar year.)
OPTOMETRIC SERVICES				
Evaluation and Management Visit			X	\$1.00-\$3.00 per visit.
Ophthalmological Evaluation			X	\$1.00-\$3.00 per exam.
Low Vision, Diagnostic, Therapy Services			X	\$0.50-\$3.00 per service.
Contact Lens Services			X	\$3.00

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
PHYSICAL THERAPY Individual or Group Therapy/Evaluation			X	Between \$0.50 and \$3.00 depending on the cost of the service. (No co-payment required after 30 hours or \$1,500 of services have been provided per recipient per calendar year.)

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
PHYSICIAN AND NURSE PRACTITIONER SERVICES (Note: Nurse Practitioners' services are limited to selected procedures and do not encompass all the areas of services listed below.) (EVALUATION & MANAGEMENT) Office/other Outpatient Visits Emergency Department Hospital Admissions Hospital Observations Surgery Tonsillectomy Bone Marrow Preventive Medical Visits (MEDICINE) Biofeedback Ophthalmological Exams				
			X	\$1.00-\$3.00 per visit.
			X	\$1.00 per visit.
			X	\$1.00-\$3.00 per visit.
			X	\$3.00 per visit.
			X	\$3.00 per surgery.
			X	\$1.00-\$3.00 per visit.
			X	\$1.00 per visit.
			X	\$1.00 per visit.
			X	\$0.50 per 60 minutes.
			X	\$1.00 per visit.

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Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
(SURGERY SERVICES)			X	\$3.00 per procedure.
(RADIOLOGY SERVICES)			X	\$3.00 per service.
(NUCLEAR MEDICINE)			X	\$3.00 per service.
(LABORATORY SERVICES)			X	\$1.00 per date of service.
(DIAGNOSTIC TESTS)			X	\$1.00 per service.
PODIATRY SERVICES				
Home/Office Evaluation and Management Services			X	\$1.00 - \$3.00 per visit.
Laboratory			X	\$1.00 per visit.
Radiology			X	\$3.00 per service.
Surgery			X	\$3.00 per procedure.
Mycotic Conditions and Nails			X	\$3.00 per procedure.
Casting/Strapping/Taping			X	\$1.00-\$3.00 per procedure.
Routine Foot Care			X	\$1.00 per visit.
RURAL HEALTH CLINIC SERVICES			X	\$2.00 per encounter.

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The following services are partially exempt from copayment:

1. Prescriptions for legend drugs beyond a total of \$5.00 copayment per calendar month if the recipient uses a single pharmacist as their sole provider of prescription drugs.
2. Outpatient psychotherapy services over 15 hours or \$500.00 per equivalent care, (whichever comes first) per recipient per calendar year. This equates to a maximum of \$30.00 copayment per recipient per calendar year.
3. Occupational, physical or speech therapy services over 30 hours or \$1,500.00 of equivalent care (whichever comes first), per therapy type, per recipient, per calendar year. This equates to a maximum of \$60.00 copayment per therapy type, per recipient, per calendar year.
4. Physician, podiatrist and nurse practitioner visits, laboratory, radiology, diagnostic tests, rural health clinic visits, surgery over \$30.00 per recipient per provider, per recipient, per calendar year.
5. Inpatient hospital and inpatient stays in institutions (hospitals) for mental disease services beyond \$75.00 per stay.

The following recipient groups are exempt from copayments by both Federal and State law:

1. Persons under 18 years of age.
2. Nursing home residents.
3. Persons enrolled in health maintenance organizations (HMOs).